Statement of the American Medical Rehabilitation Providers Association (AMRPA) for the House Ways and Means Health Subcommittee Hearing on Medicare Post-Acute Care Reform

Friday, June 14, 2013

On behalf of the American Medical Rehabilitation Providers Association (AMRPA), thank you for the opportunity to provide comments regarding the President's Budget and other proposals to reform Medicare post-acute care payments. AMRPA commends the Committee for convening a hearing on this important topic.

AMRPA is extremely concerned about proposed Medicare and Medicaid cuts to inpatient rehabilitation hospitals and units (IRH/Us, described by Medicare as IRFs). These cuts would severely and negatively impact IRH/Us and the patients they serve. While the cuts may be proposed under the guise of "reform", they are anything but. Rather, they are mostly outdated, pulled-off-the-shelf redistributional proposals that fail to take into account the needs of rehabilitation patients, the changing nature of the health care delivery system and the clinical judgment of expert physicians. To ensure continued access to high quality, medically necessary inpatient rehabilitative care, Congress should oppose further payment reductions to IRH/Us. Additionally, any reforms related to post-acute care should be guided by the fundamental principle that clinical decision making—both with respect to the type and site of care—should determine patient care. We urge Congress to ensure that physician judgment is central to any post-acute care reforms.

I. Rehabilitation Hospitals Provide Critically-Important Care to Individuals Working to Overcome Challenging Injuries, Disabilities and Conditions

Medical rehabilitation is a critical component of the health care delivery system. AMRPA members work daily with Medicare and Medicaid beneficiaries to maximize their health, functional skills, independence, and participation in society so they are able to return to home, work, or an active retirement. AMRPA members provide rehabilitation to patients working to overcome some of the most challenging injuries and conditions known, including brain injury, spinal cord injury, musculoskeletal injuries and diseases, stroke, and other neuromuscular problems. Medical rehabilitation prevents unnecessary medical costs in the long-term and allows patients to return to the most important people and activities in their lives.

Members of Congress are familiar with the quality medical care that patients receive in IRH/Us. Rehabilitation hospitals have provided essential and effective care for the spouses, parents, sons, daughters, and other family members of Members of Congress. Congress, along with the rest of the country, has also watched with admiration as Senator Mark Kirk (R-IL) and former Representative Gabrielle Giffords (D-AZ) have recovered from devastating injuries and medical conditions through receiving intensive medical rehabilitation services. With courage and fortitude, these individuals have relearned how to walk, speak, read, and write through rehabilitation hospital care.

As Congress considers changes to the post-acute care sector, it must ensure that patients—our families, friends, and colleagues—are not negatively impacted. Unfortunately, IRH/U's ability to provide quality, effective rehabilitation care is threatened by proposals such as market basket cuts, the 75% Rule, and "site neutral" payments.

II. Congress Should Avoid Further Cuts to IRH/Us, a Sector which has been Cut Significantly and in which Growth Concerns are Minimal

One proposal under discussion would freeze market basket updates for post-acute care providers. Congress should reject this recommendation for IRH/Us, a sector that has been cut significantly in recent years even though no unconstrained growth or spending problems exist. Before considering any further post-acute care cuts, Congress should take into account the significant reductions that are already in place or about to be implemented for IRH/Us.

Congress recently enacted significant cuts for IRH/Us. The Budget Control Act of 2011 included a two percent sequestration cut to Medicare payments. This cut is particularly significant for rehabilitation hospitals/units because on average, 60 percent of patients in IRH/Us are Medicare beneficiaries. The Affordable Care Act (ACA) also subjects inpatient hospitals, long-term care hospitals, IRH/Us, psychiatric hospitals and outpatient departments of hospitals to across the board cuts totaling $156.6 billion over 10 years. Notably, the amount and impact of these cuts will grow over time, meaning that their total impact will not be fully understood in the short-term. It should be noted that the ACA cuts impacted hospital level care provided by IRH/Us and LTACHs, *but do not apply to SNFs or home health*. These hospital and outpatient payment cuts will be incurred in addition to a $4 billion cut (over ten years) to IRH/Us enacted by the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA). MMSEA froze the IRH/U market basket update at 0% from April 1, 2008 through the end of Fiscal Year 2009 — the rehabilitation hospital field endured six full quarters without any market basket updates. Rehabilitation hospitals and units simply cannot continue to absorb additional payment reductions without such reductions adversely affecting patient access.

These proposed cuts are unwarranted for IRH/Us. Unlike other post-acute care providers that have experienced explosive growth, rehabilitation hospitals and units have seen dramatic declines in utilization over the past eight years. Since 2003, IRH/Us have had the lowest Medicare spending growth of any post-acute care provider and growth has been negative in three of the last five years. An analysis of eRehabData® shows that the total number of annual Medicare admissions has declined since the third quarter of 2003 by nearly 155,000 patients. A recent Moran Company analysis reported that Medicare IRH/U volume in the second quarter of 2012 is down 24.4 percent from the comparable period in the second quarter of 2004. In addition the number of providers has shrunk from 1,211 in 2003 to 1,162 in 2013, while the number of beds has fallen from 38,765 in 2005 to 38,265 in 2013. This has diminished capacity exactly when the large wave of American baby boomers will be placing increased demand for services on the field. Market basket reductions would further negatively impact patient access to rehabilitation care.

III. The 75% Rule is an Arbitrary Quota System that Wrongly Emphasizes Diagnostic Categories and Numeric Thresholds over the Needs of the Patient

Another proposal calls for an increase of the compliance threshold to 75% beginning in 2014. This policy would require 75% of an IRH/U's patients to have one of 13 specified diagnostic categories before it could qualify as an IRH/U for payment purposes. This policy is known as the "75% Rule," and is one of the Medicare IRH/U classification criteria.

The 75 Percent Rule is a dated policy that has been soundly rejected by Congress in the past. In 2004, the Centers for Medicare and Medicaid Services (CMS) began phasing in regulations in 2004

implementing a new 75% Rule. Congress quickly recognized that the new 75% Rule was adversely affecting access to medically necessary rehabilitation services for vulnerable elderly and disabled patients and placing insurmountable stress on IRH/Us. In order to comply with the 75% Rule, IRH/Us oftentimes were forced to decline admitting patients based on their condition category – despite the fact that they were clinically appropriate for medical rehabilitation.

The Medicare, Medicaid, SCHIP Extension Act of 2007 (MMSEA) permanently reduced the compliance threshold percentage for this classification criterion to 60%. In response to this permanent statutory relief, IRH/Us agreed to self-fund this regulatory fix through supporting a 0% market basket update from April 1, 2008 through the end of Fiscal Year 2009—six full quarters without a payment update. No other post-acute care providers or hospitals were subject to this or any comparable reimbursement cut. In addition, Congress directed CMS to conduct a study and analysis of the 75% Rule, which was performed by RTI and released by CMS in September 2009. The study did not recommend changing the current compliance threshold percentage of 60%.

There were many good reasons why Congress soundly rejected the 75% Rule. As expressed by the MedPAC Chair and Deputy CMS Administrator in recent Ways and Means Committee hearings, the 75% Rule is a "crude" and "arbitrary" standard.[1] The 75% Rule is an arbitrary quota system that wrongly emphasizes diagnostic categories and numeric thresholds as a defining characteristic of IRH/Us. The policy is not a standard by which to judge the medical appropriateness of individual patients. Indeed, the arbitrary nature of the policy was evident in 2004 when CMS began enforcing the new 75% Rule. Because of IRH/Us' need to manage to the percentage threshold, there were many instances in which patients were accepted for admission one month, while patients with the same condition and clinical profile and in need of the same treatment were not able to be admitted the following month. The 75% Rule had the effect of overriding physician decisions and patient needs in order to achieve regulatory compliance.

The dated 75% Rule policy also fails to take into account current regulatory requirements facing IRH/Us. CMS adopted new, more restrictive medical necessity coverage criteria in January 2010.[2] Under these criteria, every patient admitted to an IRH/U is subject to an intensive pre-admission screening to determine the appropriateness of intensive rehabilitation therapy. This review must be completed by a licensed rehabilitation physician within 48 hours immediately preceding the IRH/U admission and must be documented in the patient's medical record. Following admission, the rehabilitation physician must conduct a post-admission review within 24 hours to ensure the patient remains appropriate for treatment in an IRH/U and to begin the development of the patient's course of treatment. A rehabilitation physician must then develop a plan of care within four days of the patient's admission to the IRH/U. The plan of care must detail the patient's medical prognosis and the anticipated interventions, functional outcomes, and discharge destination from the IRH/U stay, thereby supporting the medical necessity of the admission. In effect, these stringent criteria currently serve as a "100% Rule", with all IRH/U patients subject to extensive scrutiny before and after admission to the IRH/U. This policy has further constrained growth and admissions in a significant way.

[1] Testimony of Glenn Hackbarth, J.D., M.A., Chairman, Medicare Payment Advisory Commission (MedPAC) before the U.S. House Ways and Means Health Subcommittee, May 15, 2013.

[2] *See* Medicare Benefit Policy Manual, Chapter 1 – Inpatient Hospital Services Covered under Part A, 110.

Additionally, the ten-year old 75% Rule recommendation does not adequately reflect the advances in medical care and technology that have created new populations who require inpatient hospital level rehabilitation. These include, among others, patients with cancer, cardiac diseases, pulmonary diseases, organ transplants, and artificial heart pump implants. Even with these new populations, inpatient rehabilitation spending as a percentage of Medicare has been declining and now is essentially flat.

Some proponents of the policy change maintain that the government would realize savings from new implementation of this policy. However, in reality the federal government is unlikely to realize such savings. In response to the 75% Rule, IRH/Us irreversibly modified their admission practices to come into compliance and reduce costs. Patients were shifted to skilled nursing homes (SNFs) or home health agencies. The highest percentage of Medicare patients now being treated in IRH/Us includes extremely medically complex individuals with complicated diseases, conditions and other neurological impairments that are more severe, more costly to manage, and require longer lengths of stay. These patients simply could not and would not receive the appropriate intensity of care in other post-acute care settings, such as nursing homes.

IV. Shifting to "Site Neutral" Payments is a Redistributional Proposal that Fails to Recognize the Differences between Sites of Post-Acute Care

Another troubling proposal would implement a policy to "equalize payments for certain conditions treated in IRFs and SNFs." The proposed payment policy would immediately apply to three conditions involving hips and knees as well as pulmonary conditions, and also provides broad discretionary authority to the Secretary to add other conditions. This proposal is usually referred to as "site neutral payment."

This proposal is deeply flawed. Site neutral payment policy fails to consider the clinical needs of patients in making decisions about the best course of care. In addition, it does not take into account the fundamental differences in staffing quality, outcomes and levels of care among post-acute care providers. It also fails to recognize the stringent requirements placed upon IRH/Us that do not apply to other post-acute care providers such as nursing homes. Site neutral payments represent a redistributional proposal under which some providers will gain market share of patients and payments at the expense of clinically appropriate, hospital-level, quality care.

Medicare requirements for IRH/Us are stringent and different from other post-acute care providers. To be classified as an IRH/U, the hospital must have a medical director and nurses who specialize in rehabilitation, have 60 percent of admissions come from 13 specific diagnoses, and can only admit patients who need 3 hours of therapy a day and have the potential to meet predetermined goals. No other post-acute care provider faces similar requirements.

Site neutral proposals fail to recognize these fundamental differences in regulatory requirements, staffing levels, and resource utilization between and among sites of care. Congress cannot impose site neutral payment rates without also creating site neutral regulatory standards. In the absence of parallel regulatory, staffing, and cost-structures, Medicare must appropriately compensate IRH/Us. Because IRH/Us only admit patients who require hospital-level care and resources, Medicare must pay hospital-level rates for this level and intensity of care. A proposal to establish "site neutral" payments ignores the IRH/U physician, nursing, hospital infrastructure and related costs that are not covered by SNF rates or required of SNFs.

Numerous studies have demonstrated that patients receiving rehabilitation in the IRH/U setting have superior functional outcomes compared to those treated by other post-acute providers, including stroke patients and hip replacement and hip fracture patients. A report prepared for CMS by RTI found that, generally, stroke patients treated in IRH/Us have greater improvement and shorter stays than stroke patients treated in SNFs.[3] Other studies support these findings. A study by Kramer et al. reported that stroke patients who were treated in an IRH/U achieved greater functional improvement compared with patients treated at a SNF.[4] Many studies have also demonstrated superior patient outcomes when hip fracture patients were treated in an IRH/U.

IRH/Us also achieve superior results in a shorter amount of time compared to other sites of care. The Medicare Payment Advisory Commission (MedPAC) found that IRH/U patients had an average length of stay of 13 days in 2011[5] compared to patients in a relatively efficient nursing home who averaged 34 days in 2009.[6] Studies by independent experts have found similar data. Munin et al. found that IRH/U patients stayed an average of 12.8 days while SNF patients stayed in the facility an average of 36.2 days.[7] SNFs are paid on a per diem basis, meaning that longer lengths of stay increase costs to the beneficiary and the Medicare program.

Moreover, an important measure of quality rehabilitation care is the percentage of patients that are discharged to the community, rather than another acute or post-acute care setting. According to CMS, a significantly higher percentage of IRH/U patients (81.1%) are able to be discharged to home after rehabilitation than nursing home patients to the community (27.8%).[8] Numerous academic studies have also demonstrated that patients who received rehabilitation in IRH/Us return to the community more often than those treated in SNFs.[9]

Interestingly CMS has failed to comprehensively analyze the comparative costs of medical rehabilitation as compared to SNF-level care over an entire episode of care. When one takes into account readmission costs (SNFs have readmission costs twice that of IRH/Us) and the higher percentages of discharge to home and community, for many Medicare beneficiaries, rehabilitative care may be the less costly alternative.

Because rehabilitation hospitals and units are able to deliver high quality care that enables most patients to return home more quickly, the Center for Medicare Advocacy and others recognize that any cost savings per treatment episode to be achieved by shifting patients from IRH/Us to other

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[3] Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, p. 212 (March 2011), http://www.medpac.gov/documents/Mar11_EntireReport.pdf.

[4] Kramer AM, Steiner JF, Schlenker RE, et al: Outcomes and costs after hip fracture and stroke. A comparison of rehabilitation settings. *JAMA* 1997;277:396-403.

[5] MedPAC March 2013 Report to Congress.

[6] *Id.* at 163. *See also* Centers for Medicare and Medicaid Services, Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2012, 76 Fed. Reg. 48486, Aug. 8, 2011.

[7] Munin MC, Seligman K, Dew MA, et al: Effect of rehabilitation site on functional recovery after hip fracture. *Arch Phys Med Rehabil* 2005;86:367-72.

[8] Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2012 Final Rule, p. 48499 http://www.gpo.gov/fdsys/pkg/FR-2011-08-08/pdf/2011-19544.pdf (last visited October 25, 2011) and MedPAC March 2013 Report to Congress.

[9] Walsh MB, Herbold J: Outcome following rehabilitation for total joint replacement at IRF and SNF: A case-controlled comparison. *Am J Phys Med Rehabil* 2006; 85:1-5. Munin MC, Seligman K, Dew MA, et al: Effect of rehabilitation site on functional recovery after hip fracture. *Arch Phys Med Rehabil* 2005;86:367-72. Kramer AM, Steiner JF, Schlenker RE, et al: Outcomes and costs after hip fracture and stroke. A comparison of rehabilitation settings. *JAMA* 1997;277:396-403.

providers will be minimal at best. Rather than simply comparing per day costs of IRH/Us and nursing homes, total costs per episode of care should be compared. As noted above, significantly longer lengths of stay, higher readmissions and lower rates of discharge to the community from SNFs add significant costs to the Medicare program that are not accounted for when simply comparing per day costs. In addition to considering costs, the comparative quality and scope of care, as well as patients' health status at discharge and beyond, must be considered in order to meaningfully assess whether nursing home care is actually less costly.

V. Congress Should Support Forward-Thinking and Effective Reforms to the Post-Acute Care System, Including Implementation of the Continuing Care Hospital

A. The CCH Would Reduce Costs and Improve Care by Moving to a Patient-Centric Delivery System Model

AMRPA agrees that the post-acute care delivery system should be improved by moving from a facility-centered to a patient-centered payment system and by improving care coordination. AMRPA has long been at the forefront of developing forward thinking solutions to challenging issues. For example, AMRPA developed the Continuing Care Hospital (CCH), a pilot project that will help move Medicare towards a more patient-centric delivery system model in post-acute care. Despite a Congressional mandate in the ACA to implement the CCH, to date CMS has failed to do so. AMRPA calls on Congress to ensure that CMS implements this important pilot.

The envisioned CCH is an amalgam of the care settings currently described as LTCHs, IRH/Us, and hospital-based SNFs that are organized, in part, to deliver intensive rehabilitation therapy programs, as well as the medical component. The CCH could be an actual building (a hospital offering some or all three levels of care) or a virtual entity (an organization that provides under common management most or all of the three levels of care in more than one building or unit).

CCHs could operate distinct units or distinct levels of service that correspond to different levels of care recognized by Medicare. A physician would make the admission decision regarding whether a patient should receive care within the CCH and also determine which intensity of care the patient would need. Payment would be determined by the patient's clinical and functional characteristics. Creation and use of performance and outcome measures are a critical component of the model. This model centers admission, treatment, and payment decisions on the needs of the patient, rather than concentrating on the specific type of the provider of care.

By focusing on the post-acute care hospital continuum, the CCH provides an innovative delivery system model and an alternative to some of the concepts proposed by the Medicare Payment Advisory Commission (MedPAC), the Obama Administration, and the Senate Finance Committee, including total acute and post-acute care bundling. The CCH model will improve quality by allowing for appropriate care based on patient need, removing barriers to access caused by the current provider requirements and payment systems, and promoting collaboration.

Additionally, the CCH model will decrease costs by creating efficiency and eliminating regulatory and administrative costs, avoiding confusing post-acute care requirements, and eliminating the costs of multiple admissions.

B. The Agency has Failed to Implement the CCH Pilot Despite a Congressional Mandate to do So

Unfortunately, this pilot has not been implemented by CMS despite a statutory requirement to do so. Under the ACA, the Secretary of the Department of Health and Human Services (HHS) must implement the CCH Pilot. Section 3023 of the ACA requires the Secretary to conduct a National Pilot Program on Payment Bundling. The ACA goes on to state that the Secretary "*shall*" (emphasis added) apply the provisions of the bundling program "to separately pilot test the continuing care hospital model." [10] The use of the term "shall" takes discretion from the Secretary with respect to implementation of the CCH. The language is clear—Congress has required the Secretary to test the CCH model.

In establishing the CCH model, the statute states that "the provisions" of the bundling pilot shall apply to the CCH with a few defined exceptions.[11] One of the provisions applicable to the bundling pilot—and by extension to the CCH model—is the effective date. The bundling pilot is to be implemented "not later than January 1, 2013." The failure by the Secretary to establish the CCH pilot by this date was a clear violation of the statute. To date, the Agency has shown no progress towards implementing this pilot.

C. The Agency's Bundling Initiatives Do Not Satisfy the Spirit of the Law

Some in the Agency have argued that CMS has complied with the "spirit" of the law by implementing various bundling pilot projects. This contention fails on its face. Because Congress requires the Secretary to test the CCH concept, an assertion that the Secretary and Department pursued the spirit of the law falls short. Even if one accepts that implementing a statute should proceed through an amorphous understanding of the spirit of the law, CMS' contention that is has followed the spirit of the CCH section fails on both interpretive and practical grounds.

First, such an argument misinterprets the spirit of the law. It is clear from the drafting of the statute that Congress intended that the CCH be tested. The CCH model is listed in two separate portions of the statute. The first section, as described above, requires that the CCH be tested as part of the National Pilot Program on Payment Bundling. However, Congress also took further steps to ensure the CCH model would be implemented. Section 3021 of the ACA creates the Center for Medicare and Medicaid Innovation (CMMI) and lists specific, detailed models the Secretary may test. One of these models is the CCH.[12] By including a second statutory section discussing the CCH, Congress is establishing a backstop to ensure that the Secretary implements the model. That the Congress would go to such lengths to ensure implementation of the CCH demonstrates the project's importance to Congress. The Secretary must implement the CCH because it is required by statute and consistent with legislative intent.

Additionally, implementing bundling demonstration programs does not fulfill the statutory requirement to test the CCH because of the fundamental differences between the bundling pilots and the CCH concept. On August 23, 2011, CMS invited providers to apply to help test and develop four different models of bundling payments as part of the Bundled Payment for Care

[10] Sec. 10308 of the ACA.
[11] *Id.*
[12] Sec. 3021 of the ACA.

Initiative (BPCI). Unfortunately, these four models are so different in practice from the CCH that they do not fulfill the statutory mandate to implement the CCH.

As noted above, the list of CMMI's potential projects includes the CCH. Thus, in theory, the CMMI could satisfy the statutory mandate to test the CCH concept if it were to engage in a CCH pilot; however, the Agency has not done so with the BPCI. The statute authorizes the CMMI to implement a model of "continuing care hospitals that offer inpatient rehabilitation, long-term care hospitals, and home health or nursing care during an inpatient stay and the 30 days immediately following discharge."[13] None of the four bundling models meet this definition of the CCH.

Model 1 of the bundling initiative is titled "Retrospective Acute Care Hospital Stay Only." The episode of care for this model would be defined as the inpatient stay in the general acute care hospital. Because the CCH focuses on a stay in a comprehensive CCH plus 30 days after discharge, this model is not similar to the CCH.

Model 2, "Retrospective Acute Care Hospital Stay plus Post-Acute Care," comes closer to fitting the CCH characteristics but still does not meet the statutory mandate to test the CCH concept. In Model 2, the episode of care would include the inpatient stay and post-acute care and would end, at the applicant's option, either a minimum of 30 or 90 days after discharge. This model differs from the CCH because there is no indication that the model integrates care like the CCH. One of the benefits of the CCH is its emphasis on eliminating silos of care and basing treatment decisions on what is best for the patient. There is no indication that Model 2 would achieve these ends.

Model 3, Retrospective Post-Acute Care Only, would begin at the initiation of post-acute care and would include the participation of a SNF, IRF, LTCH or Home Health Agency (HHA). Again, because the care is not integrated, this model does not satisfy the requirement to test the CCH.

Finally, Model 4, Acute Care Hospital Stay Only, involves only the inpatient stay. Because the CCH focuses on post-acute care, Model 4 does not satisfy the requirement to test the CCH.

That the BPCI does not work as a substitute for the CCH is borne out by the experiences of a number of rehabilitation hospitals/units. A significant number of rehabilitation hospitals submitted letters of intent and attempted to participate in the BPCI but could not because of the structure and design of the project as well as problematic data issues. Indeed, it is questionable whether the Agency has found any entities meeting the definition of CCH that are able to participate in the Initiative. Inability to do so may, in fact, demonstrate a disconnect between the requirements of the Initiative and the characteristics of the CCH.

For all these reasons, implementation of the BPCI does not fulfill HHS' statutory requirement to implement the CCH model pilot in Section 3023. We request that the Committee use its oversight authority to ensure implementation of the CCH pilot by CMS.

VI. Conclusion

Thank you for the opportunity to provide comments on this important issue. AMRPA looks forward to working with the Committee to ensure patients continue to have access to medically-

[13] Sec. 3021 of ACA.

necessary medical rehabilitation care. If you have any questions about these recommendations, please contact Carolyn Zollar (czollar@amrpa.org) at 202-223-1920 or Martha Kendrick (mkendrick@pattonboggs.com) at 202-457-6520.

Sincerely,

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